

Millions of Low-Income Americans Can't Get Medicaid:
What Can Be Done?

Stan Dorn, J.D.

The Urban Institute

Research Report

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes the development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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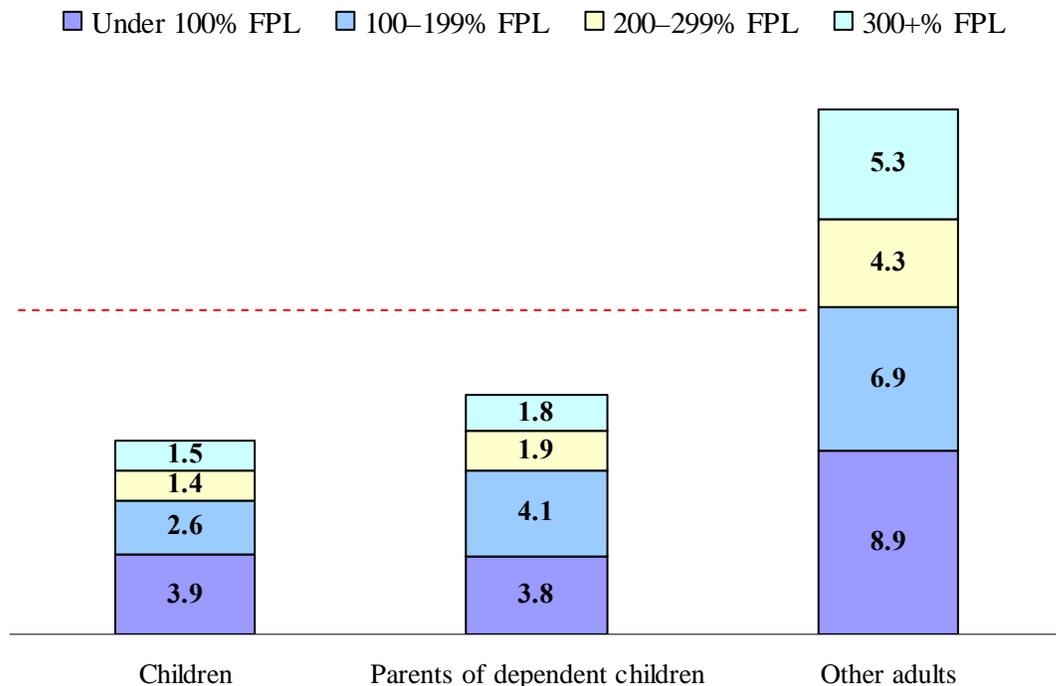
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EXECUTIVE SUMMARY

Medicaid covers adults only if they fit within federally defined eligibility categories. Federal law prohibits state Medicaid programs from covering adults, no matter how poor they are, unless they are pregnant, caring for dependent children, severely disabled, or elderly. Section 1115 of the Social Security Act permits the secretary of Health and Human Services (HHS) to waive this prohibition, but waivers provide no additional federal funds, so few states use them to provide such coverage.

Adults outside the federally defined eligibility categories represent more than half of all poor uninsured and more than half of all uninsured with incomes at or below 200 percent of the federal poverty level (FPL). Put simply, poor and near-poor noncategorical adults (e.g., those under 200 percent of FPL) comprise the bulk of the uninsured, outnumbering all uninsured parents and all uninsured children (Figure ES-1).

Figure ES-1: Uninsured under Age 65, by Income and Relationship to Children, 2006 (millions)



Source: Kaiser Commission on Medicaid and the Uninsured, Urban Institute, October 2007.

Noncategorical uninsured adults are a diverse group, ranging from young adults starting out in the working world to empty nesters in their 50s and 60s. As with other uninsured persons, the absence of health coverage is associated with significant difficulties accessing care. Among uninsured adults ages 19–29, for example, 57 percent go without essential care at some point during the year. The same is true of only 31 percent of such adults in the same age group who have coverage.

The impact on older noncategorical adults is even starker. Almost all uninsured adults ages 55–64 fall outside Medicaid eligibility categories, even though more than half are poor or near-poor. According to one analysis, if all adults ages 55–64 were insured, the percentage who die over an eight-year period would fall from 6.7 percent to 3.9 percent. Another study estimated that more than 13,000 adults in this age group die each year because they lack insurance.

This paper proceeds on the author's assumption that, to provide health insurance to at least the poorest among noncategorical adults, Medicaid would be the coverage instrument of choice. Other policies that may be appropriate to consider for covering noncategorical adults with slightly higher incomes are outside the scope of the paper.

Three general approaches are available to federal policymakers who wish to restructure Medicaid to cover low-income, noncategorical adults.

- The first approach would liberalize or eliminate the rules under which waivers are granted by allowing states to obtain additional federal funds to cover the cost of newly eligible adults—in effect, liberalizing or repealing the federal budget neutrality requirement for 1115 waivers. While this strategy would represent a step forward for uninsured adults, it would not surmount the intrinsic limitations of waivers. Waiver decisions are often made behind closed doors and greatly influenced by the shifting policy preferences of the administration in power. Some state officials are reluctant to propose waivers, fearing that federal officials might require unrelated policy changes as a precondition to granting waivers. Seeking waivers is administratively cumbersome and costly. Moreover, the budget neutrality policy is long-standing; proposals to overturn or liberalize it could evoke strong opposition from advocates of federal budget restraint, given the waiver statute's broad grant of discretionary authority to the secretary of HHS.
- A second approach would change Medicaid eligibility from categorical to purely need-based. Everyone with income below a specified level would qualify, without regard to category. People with incomes above that level would be ineligible. In addition to the virtue of simplicity, this strategy might achieve significant administrative savings by avoiding the need for public agencies to sort applicants among various eligibility categories. Medicaid agencies could apply one set of rules to all applicants, instead of using different rules for different eligibility groups. This approach could also be defended on equity grounds. If income alone were the basis of eligibility, it would no longer be the case that some people are covered to relatively high income levels while others with substantially lower incomes are left uninsured.

However, using income as the sole basis of coverage could result in millions of people losing coverage. Examples of current Medicaid eligibility categories that extend to relatively high income levels include coverage for nursing home residents who spend down excess income to qualify, near-poor children, employed people with disabilities, low-income pregnant women without other sources of insurance, and families transitioning from welfare to employment. For example, in 2006, granting Medicaid eligibility up to 150 percent of the federal poverty level while denying it to people with incomes above that level would have terminated health coverage for 6.4 million children and 4.4 million adults who had incomes above 150 percent of FPL and received Medicaid and the State Children's Health Insurance (SCHIP). Eliminating their coverage while covering all adults with incomes at or below

150 percent of FPL would serve equity, but with grim consequences. Current enrollees could be grandfathered in so they would not lose coverage, but Medicaid would be denied to similarly situated individuals in the future.

A variant of this approach would cover all adults up to specified income levels while giving states the flexibility to cover state-defined higher-income groups. While it might prevent coverage losses, this approach could raise the cost of reform by extending Medicaid to higher-income people outside current eligibility categories.

- A third approach would maintain existing categories *and* create a new *catch-all* eligibility category for adults with incomes under specified levels. This approach has the disadvantages of retaining existing complexity and achieving fewer administrative savings than the second approach. However, it has the advantage of expanding coverage for the uninsured without denying access to health care to other groups that qualify under current law or increasing federal spending on higher-income groups.

Regardless of the approach policymakers take, numerous policy design details would need to be resolved, including the respective roles and responsibilities of federal and state government and the financial eligibility standards that would apply to newly covered adults.

INTRODUCTION

Federal law forbids Medicaid from covering adults, no matter how poor, unless they are pregnant, elderly, severely disabled, or caring for dependent children. A few states have obtained federal waivers that allow them to cover adults outside these categories, but no additional federal dollars accompany such waivers. A few other states use their own resources to fund Medicaid coverage for adults outside the federally defined categories, but these states are the exception. The result is that more than half of all low-income uninsured persons are adults outside federally defined eligibility categories.

This paper begins by analyzing the current state of affairs for these adults. It then considers various approaches to providing them with Medicaid coverage. It concludes by identifying key design questions that need to be analyzed to make specific policy recommendations at the federal level.

Three introductory comments are important. First, in terms of nomenclature, this paper refers to people with incomes at or below 100 percent of the federal poverty level (FPL) as “poor.”¹ People with incomes between 100 and 200 percent of FPL are called “near-poor.” Poor and near-poor people together (that is, all people with incomes at or below 200 percent of FPL) are referred to as “low-income.”

Second, because the paper tries to compile pertinent prior research from diverse sources, some of its numbers come from analyses of different sets of survey data. The general pictures painted by these analyses are compatible, but the precise numbers vary somewhat.

Finally, the paper limits itself to the analysis of how Medicaid can be used to cover noncategorical adults, focusing on those with low incomes. For noncategorical adults with somewhat higher incomes, other coverage strategies also deserve analysis, including refundable, advanceable federal income tax credits for uninsured adults with incomes above specified levels; a “buy-in” to Medicare for older, uninsured adults; and measures to increase the number of young adults covered as dependents on family policies. A discussion of these alternative approaches for moderate-income populations is beyond the scope of this paper.

¹ In 2008, the FPL is \$10,400 a year for a single person, \$14,000 for a couple, \$17,600 for a three-person household, \$21,200 for a family of four, and so on.

CURRENT MEDICAID COVERAGE FOR LOW-INCOME ADULTS

To qualify for Medicaid, it is not enough to be poor. An individual must also fit within a federally defined eligibility category. Some categories are mandatory, while others are optional.² If a state wishes to provide Medicaid coverage, it must cover all persons who fall into the federally mandated categories. For both mandatory and optional eligibility groups, the federal government will pay a matching share of covered health care service costs. In 2008, this share ranges from 50 to 76 percent, depending on the state. To qualify for either mandatory or optional Medicaid coverage as an adult, one must be pregnant; age 65 or older; disabled, as defined by the Supplemental Security Income (SSI) program, which requires a finding of severe and permanent disability that precludes substantial gainful employment; or currently caring for dependent children.³

States can cover adults outside these categories only by obtaining a waiver under section 1115 of the Social Security Act.⁴ This section permits “experimental, pilot, or demonstration project[s] which, in the judgment of the Secretary [of Health and Human Services], [are] likely to assist in promoting the objectives of” various statutes, including federal Medicaid law. The Office of Management and Budget (OMB) has a long-standing administrative requirement that such waivers must be *budget neutral*, meaning that projected federal expenditures may not exceed those forecast under current law.

Some states have financed section 1115 coverage of previously ineligible adults by reducing Medicaid spending on other beneficiaries; redirecting Medicaid funds from certain hospital allocations; and, in a few cases, using unclaimed allocations under SCHIP (Dorn et al., 2004; Gill et al., 2003).⁵ As of April 2008, only 12 states provided comprehensive coverage to all categorically ineligible adults with incomes up to at least 100 percent FPL, through either 1115 waivers or 100 percent state funding.⁶

2 For example, all Medicaid programs must cover children under age six with incomes at or below 133 percent of FPL and children ages 6–18 with incomes at or below 100 percent of FPL. States have the option to provide Medicaid coverage to children at higher income levels and to cover certain groups of children ages 19–20.

3 Several limited eligibility categories are available, at state option, for other adults. For example, states can cover women diagnosed with cervical or breast cancer and adults diagnosed with tuberculosis, even if they do not otherwise fit into federal eligibility categories.

4 42 U.S.C. 1315(a).

5 New SCHIP waivers are no longer available to cover childless adults.

6 Providing such coverage through 1115 waivers were Arizona, Delaware, Hawaii, Maine, Massachusetts, New Mexico, New York, Oregon, and Vermont. The District of Columbia, Minnesota, and Washington used state-only dollars to provide such coverage. Many of these states went above 100 percent of FPL in extending eligibility. Limited benefits, limited eligibility, or both were provided by Pennsylvania, using state-only dollars, and by Arkansas, the District of Columbia, Iowa, Idaho, Indiana, Maryland, Michigan, Missouri (implementation forthcoming), Montana, Oklahoma, Tennessee, and Utah using 1115 waivers (Keavney Klein and Sonya Schwartz, National Academy for State Health Policy, unpublished data, April 2008). These states either covered a limited subset of noncategorical adults (such as those working for small firms) or provided fewer benefits than are offered by typical employer-sponsored insurance.

ORIGINS OF THE EXCLUSION OF NONCATEGORICAL ADULTS

Medicaid's exclusion of coverage for noncategorical adults reflects decisions made long ago in the design of cash assistance programs. In response to the economic effects of the Great Depression, the Social Security Act of 1935 created federally matched cash assistance programs for the elderly, blind, disabled, and certain families with dependent children. This approach departed from the previous tradition of locally based relief for the poor, which began in England with the Elizabethan Poor Law of 1601 and was exported to colonial America (Barker, 1995). After the enactment of Depression-era cash aid programs, localities were responsible for the remaining low-income people who were outside the scope of the new cash assistance programs, including noncategorical adults.

When Medicare was created in 1965, Medicaid was added to the legislation to provide health coverage to recipients of federally supported cash assistance for the poor. Medicaid thus excluded adults who were not elderly, disabled, or caring for dependent children (Dorn et al., 2004).

This history reflects attitudes about which groups of low-income people "deserved" federally subsidized cash assistance. When those programs were established, many policymakers and a large portion of the public viewed healthy, working-age adults without child care responsibilities as unworthy of help, since they should be capable of supporting themselves (Handler, 1995). However, that judgment was made during the 1930s in the context of income assistance, not health care.

EVOLUTION OF MEDICAID ELIGIBILITY

As the Medicaid program evolved, eligibility expanded incrementally. For example, the original program's provision of health coverage for recipients of Aid to Families with Dependent Children (AFDC) grew to include children who would have received AFDC but for certain factors (such as their grandparents' income), pregnant women who would have qualified for AFDC if their children had already been born, and children and pregnant women with incomes up to various percentages of FPL. However, such gradual expansions have not directly addressed Medicaid's basic eligibility structure, which is limited to pregnant women, families with dependent children, the elderly, and people with disabilities (Dorn et al., 2004).

Even people who believe that all able-bodied adults should be able to earn enough money to buy food and pay rent⁷ acknowledge that few poor people can afford private health insurance. Public opinion research suggests strong potential support for extending Medicaid to all of the poor, without categorical restriction. One recent poll conducted by noted Republican pollster Linda DiVall, on behalf of the Federation of American Hospitals (FAH), asked respondents to describe their feelings about many different groups involved in the national health coverage debate. The researchers found that voters had more sympathy and support for poor people without health

⁷ This perspective was manifest during the congressional debate over welfare reform in 1996, when childless adults were singled out for particularly large reductions in Food Stamp eligibility (Center on Budget and Policy Priorities, 1996).

insurance than for any other group. In addition to general emotional reactions, the poll analyzed voters' attitudes toward specific health coverage expansion proposals. Overall, 71 percent of respondents supported expanding Medicaid to all uninsured Americans with annual incomes at or below FPL (DiVall et al., 2007).

Along similar lines, according to an early survey of Massachusetts residents examining that state's reform legislation, the policy element receiving the most support (79 percent) was providing "free health care to those individuals below the poverty level." (7NEWS-Suffolk University, 2007). Further research is needed, but even these initial, limited examinations suggest potential public receptivity to extending Medicaid to low-income, uninsured, noncategorical adults.

Taken together, these public opinion analyses suggest the following question: Should national health policy in the early 21st century continue to be driven by the perceptions of 1935 lawmakers about which groups deserved federally matched cash assistance? This question is further sharpened by considering the consequences of Medicaid's categorical eligibility restrictions, as discussed in the next section.

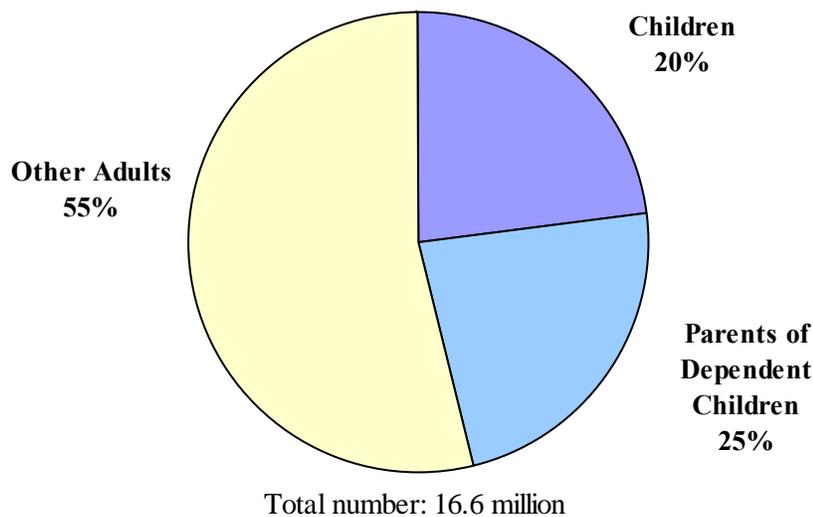
EFFECT OF MEDICAID'S CATEGORICAL RESTRICTIONS

To explore the consequences of Medicaid's limitation of eligibility to adults who meet federally defined categorical requirements, this section discusses three topics: the proportion of uninsured Americans who are categorically ineligible adults; the characteristics of uninsured, categorically ineligible adults; and the impact of uninsurance on such adults' access to care and health status.

PROPORTION OF UNINSURED WHO ARE CATEGORICALLY INELIGIBLE ADULTS

Given the federal bar on Medicaid coverage for noncategorical adults (described above), it should come as no surprise that they comprised the majority (55 percent) of all poor uninsured in 2006 (figure 1).

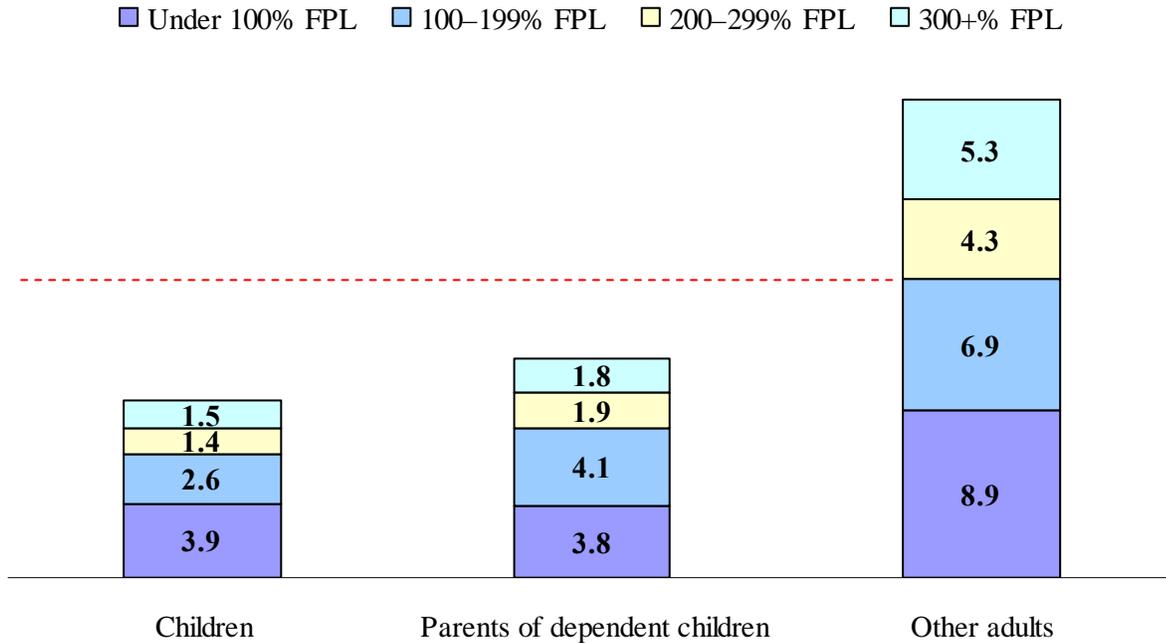
Figure 1: Uninsured under Age 65 with Incomes at or below 100 Percent of FPL, by Relationship to Children: 2006



Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute (KCMU/UI), October 2007.

Poor and near-poor noncategorical adults (e.g., those under 200 percent of the FPL) constitute the largest group of uninsured, outnumbering all uninsured children and all uninsured parents (figure 2).

Figure 2: Uninsured under Age 65, by Income and Relationship to Children: 2006 (millions)



Source: KCMU/UI, October 2007.

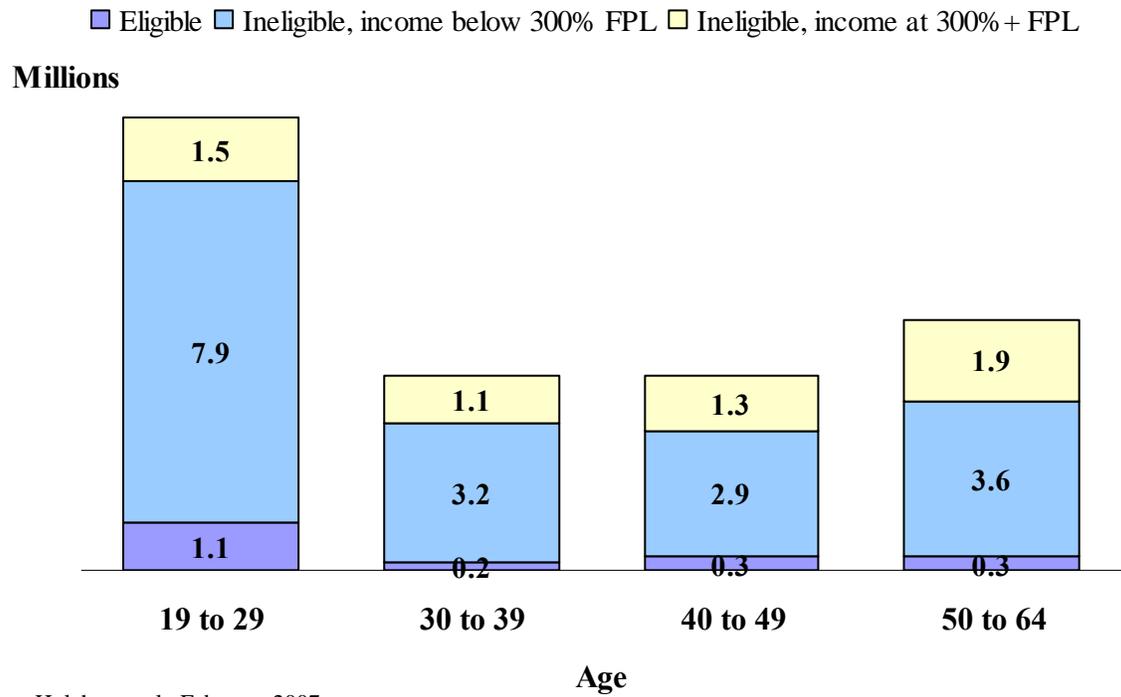
CHARACTERISTICS OF UNINSURED CATEGORICALLY INELIGIBLE ADULTS

Uninsured, noncategorical adults are diverse. This section explores their ages and other selected characteristics.

Age

The largest group of uninsured, childless adults comprises young adults with low to moderate incomes. People in their 50s and 60s (including childless adults and empty nesters) make up the second-largest group (figure 3).

Figure 3: Uninsured Noncategorical Adults, by Age, Income, and Eligibility for Medicaid/SCHIP: 2004

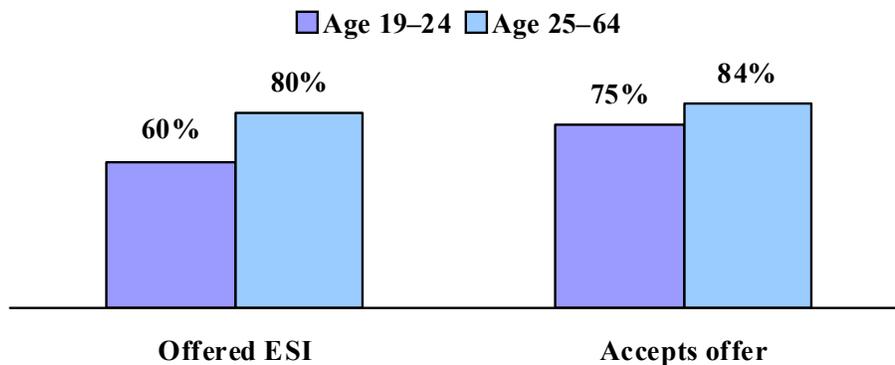


Source: Holahan et al., February 2007.

Why Are So Many Young Adults Uninsured?

Young adults are frequently caricatured as “young immortals” who prefer to spend money on surfboards rather than health insurance. In fact, probably the most important reason young adults are often uninsured is that, starting out in the working world, they are more likely than older workers to have entry-level jobs that pay little and provide few benefits. When offered employer-sponsored insurance (ESI), the vast majority of them accept it (figure 4.1), even though the average annual worker contributions for single and family coverage are now \$694 and \$3,281, respectively (KFF/HRET, 2007), and even though ESI premiums charged to young adults reflect all health care costs experienced by the insured group, include the cost of older workers.

Figure 4.1: Percentage of Workers Offered Employer-Sponsored Insurance and Accepting the Offer, by Age: 2005



Source: Clemans-Cope and Garrett, 2006. Calculations by S. Dorn, March 2007.

Uninsurance among young adults is principally (though not entirely) a function of low income, not a choice to go without coverage (figure 4.2).

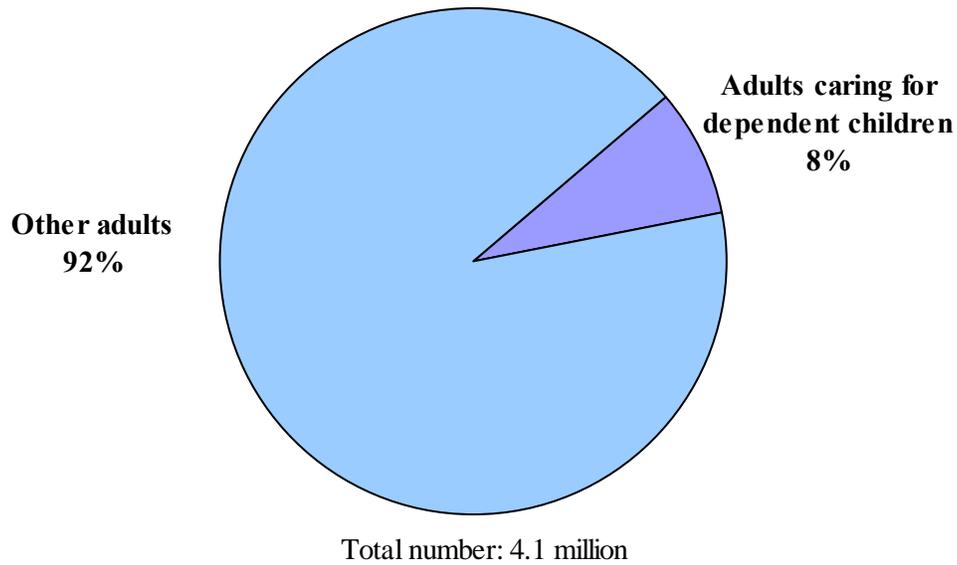
Figure 4.2: Percentage of Adults Ages 19-29 without Health Coverage, by Income: 2005



Source: Collins et al., 2007.

Focusing more closely on the characteristics of the older uninsured, the vast majority are noncategorical adults. Fewer than 1 in 10 (8 percent) uninsured adults ages 55-64 currently cares for a dependent child (figure 5).

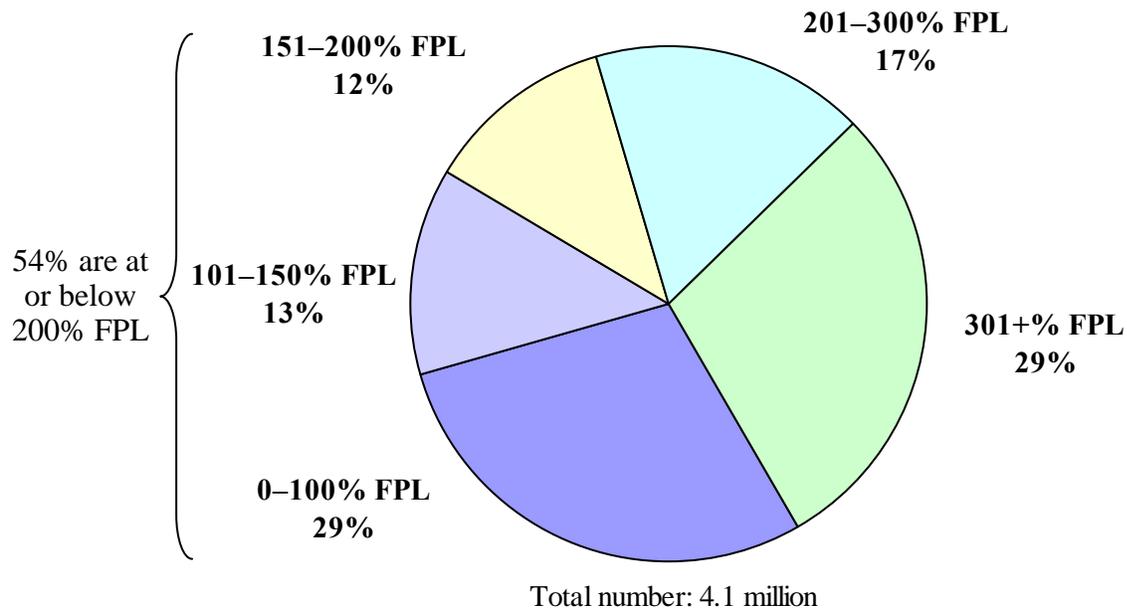
Figure 5: Uninsured Adults Ages 55–64, by Parenthood: 2006



Source: KCMU/UI, 2007.

Although the near-elderly tend to have higher incomes than younger adults, more than half of the near-elderly uninsured (54 percent) have incomes at or below 200 percent of FPL (figure 6).

Figure 6: Uninsured Childless Adults Ages 55–64, by Income: 2006

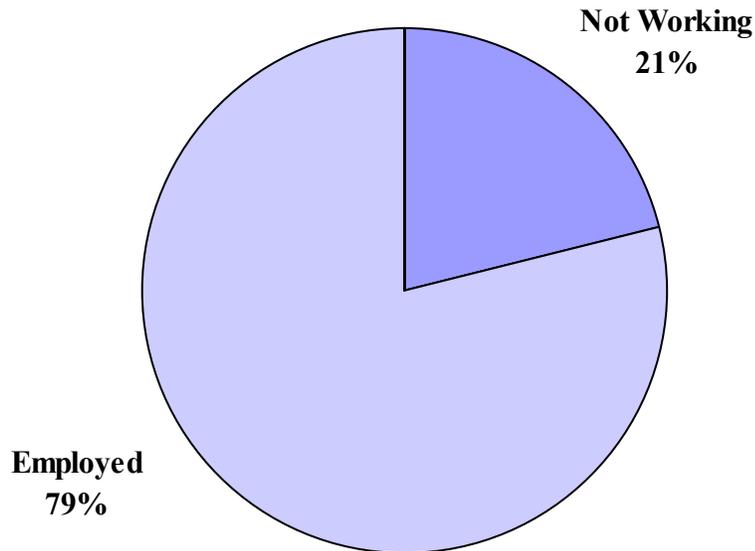


Source: Urban Institute, unpublished estimates from the 2007 ASEC to the Current Population Survey.

Employment Status, Citizenship Status, and Race/Ethnicity

In important ways, uninsured, childless adults are like other uninsured persons. They tend to be low-income workers and U.S. citizens (figures 7, 8, 9). Most are white, though more than two in five (42 percent) are African American or Hispanic (Figure 10).

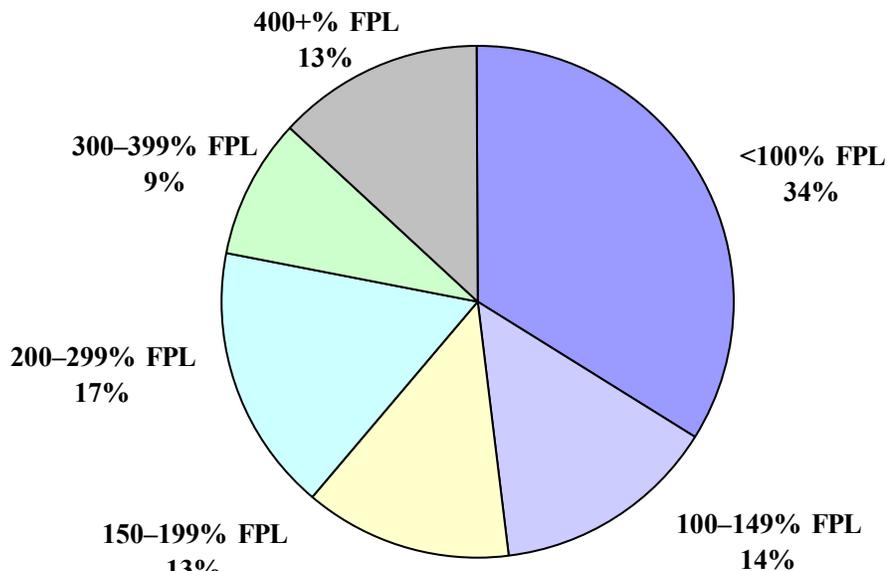
Figure 7: Uninsured Noncategorical Adults, by Employment: 2006



Total number: 25.5 million

Source: KCMU/UI, 2007.

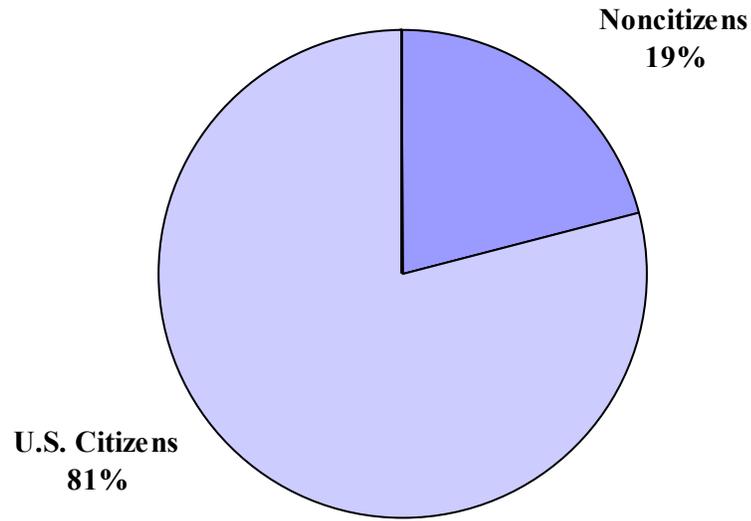
Figure 8: Uninsured Noncategorical Adults, by Income Level: 2006



Total number: 25.5 million

Source: KCMU/UI, 2007.

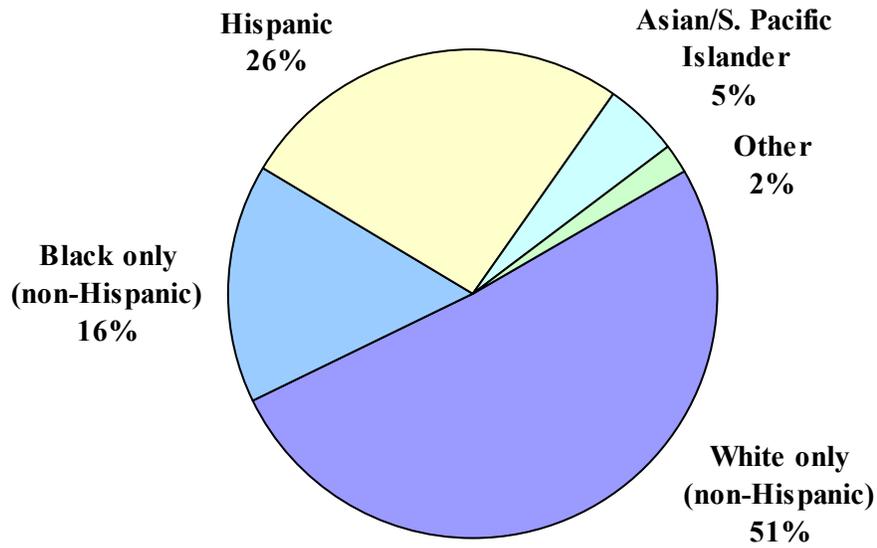
Figure 9: Uninsured Noncategorical Adults, by Citizenship: 2006



Total number: 25.5 million

Source: KCMU/UI, 2007.

Figure 10: Uninsured Noncategorical Adults, by Race and Ethnicity: 2006



Total number: 25.5 million

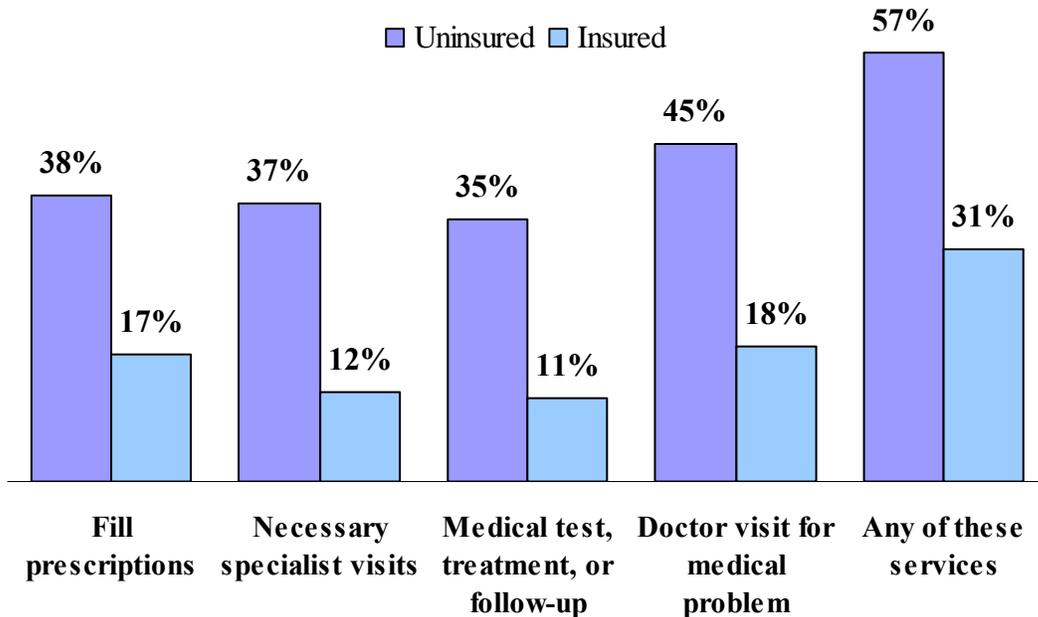
Source: KCMU/UI, 2007.

IMPACT OF LACK OF INSURANCE ON ACCESS AND HEALTH STATUS

A considerable body of work demonstrates the impact of lack of insurance on access to care and health status (Dorn, 2008; Institute of Medicine, 2002). Research has shown that this pattern applies to the two largest groups of noncategorical adults: young adults and older adults in their 50s and 60s.

In 2005, more than half (57 percent) of all uninsured young adults ages 19–29 reported going without essential care at least once during the year, compared with less than a third (31 percent) of those with health coverage (figure 11).

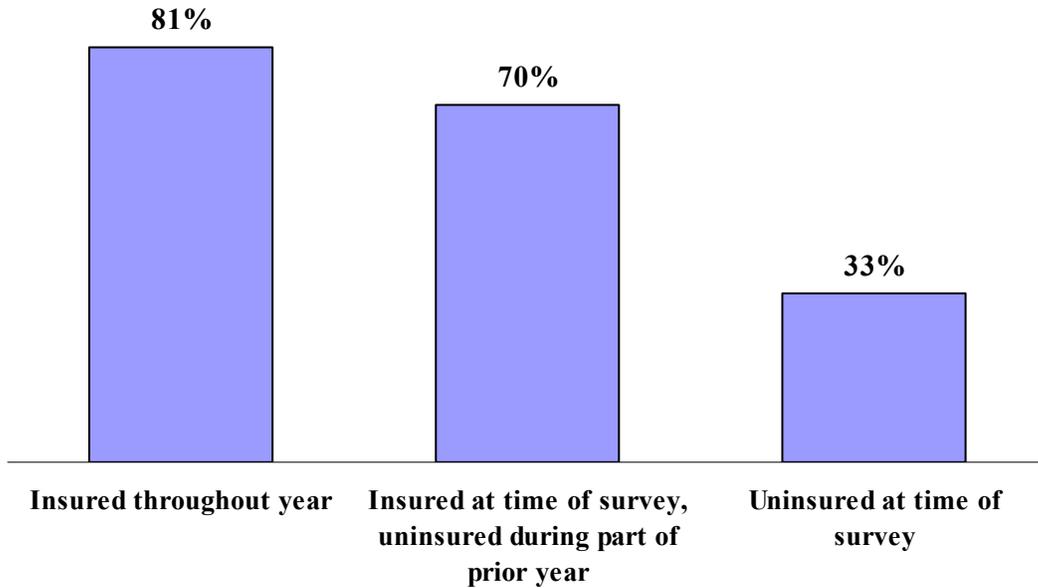
Figure 11: Percentage of Adults Ages 19–29 Reporting Going without Various Services Because of Cost, by Health Insurance Status: 2005



Source: Collins et al., 2007. Note: This figure compares access problems for (a) individuals who reported being uninsured at the time of the survey with (b) individuals who reported having insurance both at the time of the survey and throughout the previous year. Other data in the study show the extent of access problems for individuals with health coverage at the time of the survey who were uninsured during part of the previous year.

Young adults who had health coverage were much more likely to have a regular doctor (figure 12).

Figure 12: Percentage of Adults Ages 19–29 Reporting Having a Regular Doctor, by Health Insurance Status: 2005

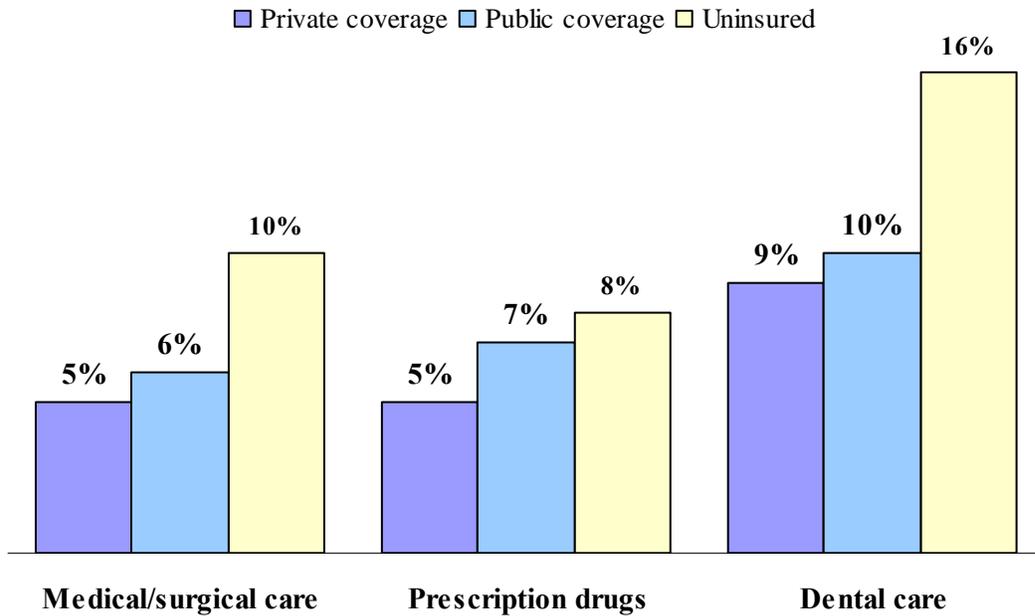


Source: Collins et al., 2007.

It is important to keep in mind that these data simply report associations among young adults' insurance status, receipt of care, and usual source of care. They do not provide a solid basis for inferring causation.

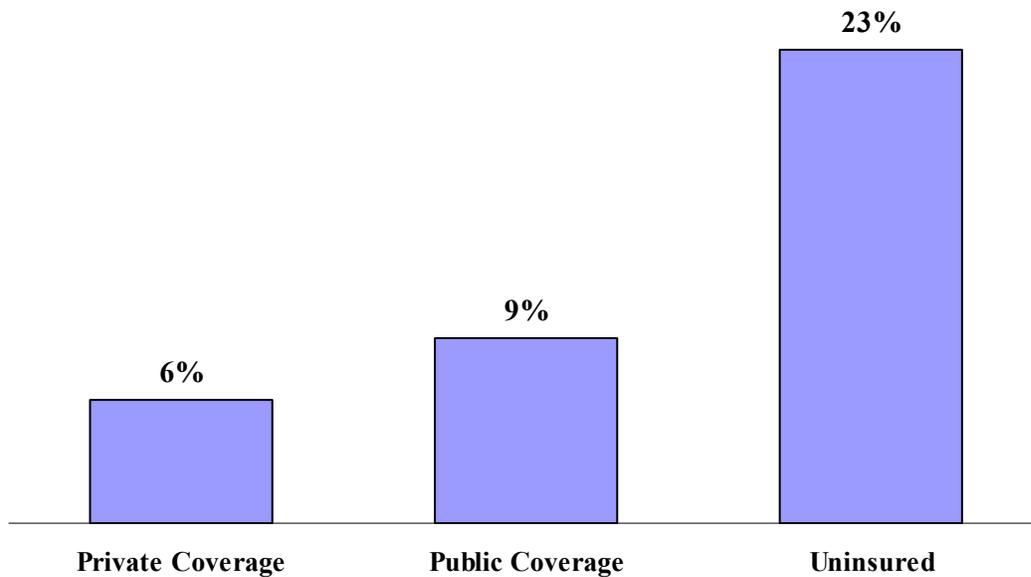
By contrast, research on older adults finds a strong association between insurance status and access to care after controlling for multiple variables. After controlling for income, insurance, age, sex, work status, health status, activity limitation, and parental status, a 2004 study found statistically significant relationships between lack of insurance and the absence of a usual source of care, as well as increased likelihood of going without necessary health care (figures 13 and 14).

Figure 13: Likelihood of Adults Ages 55–64 Going without Various Kinds of Necessary Care, by Insurance Status, Controlling for Multiple Factors: 2002



Source: Holahan, 2004.

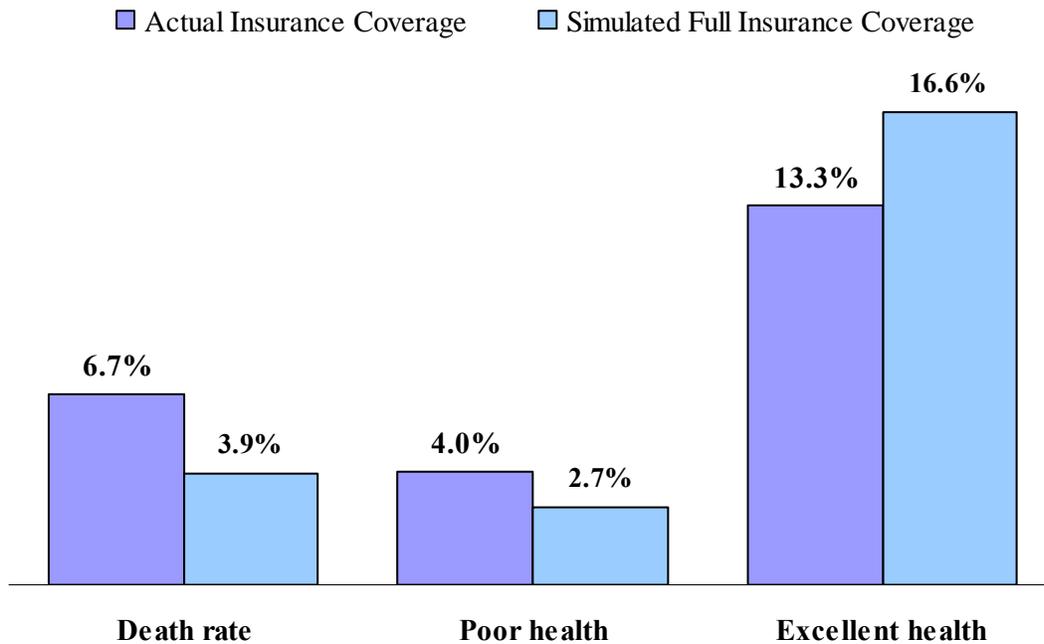
Figure 14: Likelihood of Adults Ages 55–64 Lacking a Usual Source of Care, by Insurance Status, Controlling for Multiple Factors: 2002



Source: Holahan, 2004. Calculations by S. Dorn, March 2007.

Given that uninsured, older adults experience impaired access to care, it is not surprising that their absence of health coverage appears to cause serious adverse health outcomes. A recent study found that after controlling for the effects of income, age, sex, work status, and potential differences in health status, providing health coverage to adults ages 55–64 would reduce deaths over an eight-year period from 6.7 percent to 3.9 percent in this age group and would significantly increase the proportion of such adults experiencing good health (figure 15).

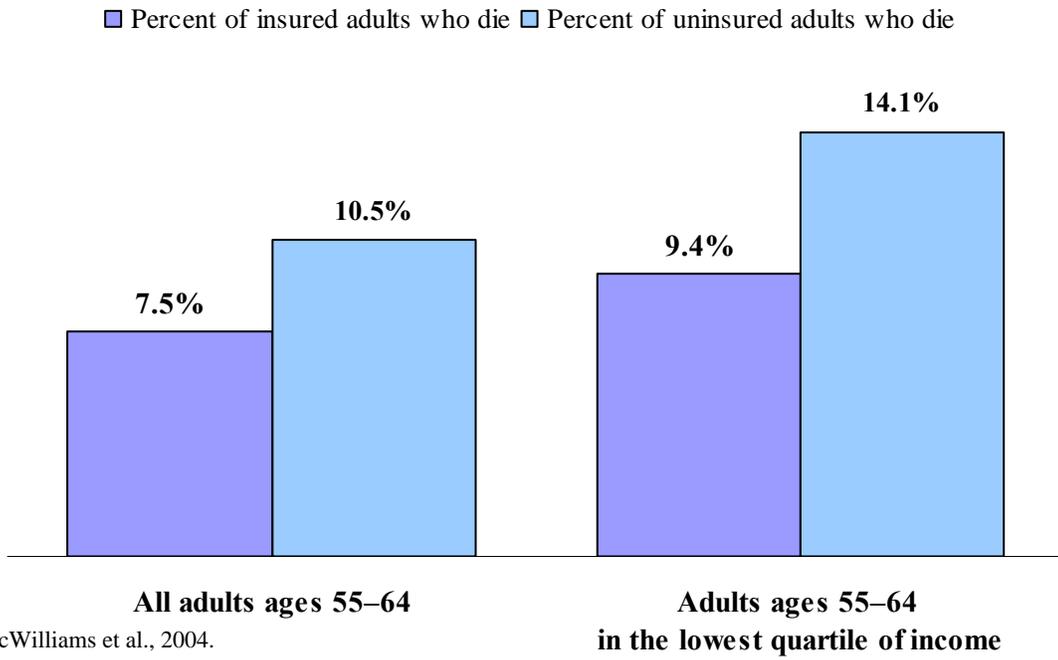
Figure 15: Impact of Health Insurance Coverage on Health Status for Adults Ages 55–64, Controlling for Multiple Factors: 1992–2000



Source: Hadley and Waidmann, 2006.

Another recent study of adults ages 55–64 found that—after controlling for race, income, wealth, education, recent hospital stays and changes in health status, household size, job stress, alcohol use, exercise, and obesity—lack of insurance increased older adults’ risk of dying over an eight-year period from 7.5 percent to 10.5 percent, with even greater effects observed among the lowest-income adults (figure 16). The study estimated that, among such near-elderly adults alone, more than 13,000 die every year because of lack of insurance, “placing it third on a list of leading causes of death for this age group, below only heart disease and cancer” (McWilliams et al., 2004).

Figure 16: Effect of Insurance on Risk of Death within Eight Years, Controlling for Multiple Factors: 2002



REFORMING CATEGORICAL ELIGIBILITY: THREE APPROACHES

Several approaches are available to federal policymakers who seek to provide low-income, noncategorical adults with health coverage through Medicaid. This section discusses three general policy options: changing the 1115 waiver process to modify or eliminate the requirement of budget neutrality, replacing Medicaid's categorical structure of eligibility with purely income-based eligibility, and creating a new Medicaid eligibility category for all adults with incomes below specified levels.

ALTER THE BUDGET NEUTRALITY REQUIREMENT FOR SECTION 1115 WAIVERS

This approach could make it easier for states to obtain 1115 waivers to cover adults on the basis of income rather than category. Such coverage expansions could be entirely exempt from the federal requirement for budget neutrality. Alternatively, the Centers for Medicare and Medicaid Services (CMS) could be directed to take Medicare savings into account in assessing budget neutrality. Such a policy could make it easier for states to expand coverage to the near-elderly, given the emerging evidence that when adults over age 50 gain coverage, their eventual Medicare costs decline (Hadley and Waidmann, 2006; McWilliams et al., 2007). This approach would permit more states to receive waivers that allow them to access federal matching funds to pay health coverage costs for noncategorical adults.

Taking Medicare savings into account in the budget neutrality calculation would be consistent with the goal of budget neutrality—that is, preventing waivers from increasing net federal spending. However, whether budget neutrality is adjusted in this way or entirely eliminated, the expanded use of waivers to cover noncategorical adults has several limitations. First, the process of seeking waivers and negotiating terms and conditions with federal officials can be costly and time-consuming. By contrast, to implement eligibility options that are not based on waivers, states make “state plan amendments” by simply checking boxes on a preprinted federal form.⁸

Second, reforming the 1115 waiver process would retain an inequitable feature of the current law. Presently, if a state wishes to cover low-income parents of children under age 18, it may do so up to any desired income level by state plan amendment. In contrast, if a state wants to cover equally needy adults whose children turn 18 or who never had children, it must obtain special approval through the waiver process. It is difficult to justify different treatment of equally low-income uninsured adults solely on the basis of whether they are currently caring for a dependent child.

⁸ In recent years, the state plan amendment process has grown more challenging. Federal officials increasingly use such amendments to examine provisions of state Medicaid plans that are unrelated to proposed amendments.

Third, the 1115 waiver process lacks transparency. Negotiations between state and federal officials take place behind closed doors, with key issues frequently remaining outside public scrutiny. State officials have expressed concerns about varying and inconsistent treatment among states (Schwartz et al., 2006), and advocates have objected to the lack of meaningful opportunities to become engaged in the policymaking process (Government Accountability Office, 2008). Waivers that expand coverage to some beneficiaries can, at the same time, reduce benefits or impose new costs on other beneficiaries (Gill et al., 2003). Moreover, federal officials sometimes use waiver requests as leverage to demand other, entirely unrelated changes to state Medicaid programs. For example, several recent waiver requests were granted on the condition that states change their methods for financing their share of overall program costs, including program components not directly related to the requested waivers (Schwartz et al., 2006).

Along similar lines, before the creation of a federal prescription drug benefit, federal approval of some waivers seeking to provide a Medicaid-covered prescription drug benefit to certain seniors was conditioned on the states' willingness to accept global caps on all Medicaid spending for the elderly (Mann and Alker, 2004). Use of waivers to leverage unrelated policy changes can deter state officials from proposing even relatively innocuous waivers.

A proposal to eliminate or liberalize the budget neutrality requirement, even for a limited class of waivers, may evoke vigorous opposition from the Office of Management and Budget and other policymakers concerned about the federal budget deficit. The repeal or significant weakening of the budget-neutrality requirement could greatly increase federal expenditures, as section 1115 permits almost any demonstration project that "in the judgment of the [HHS] Secretary, is likely to assist in promoting the objectives" of SSI, Medicaid, Temporary Assistance for Needy Families, or SCHIP. Without a clear budget-neutrality standard, this kind of open-ended authority for policy change could be seen as creating serious fiscal risks (Government Accountability Office, 2008).

ELIMINATE CATEGORICAL ELIGIBILITY

Transforming Medicaid from a categorical to an income-based program has considerable appeal. This reform seems simple and straightforward. Not only would it provide coverage to all Americans below a specified income level, it would substantially reduce costs associated with administering the current system of more than 50 discrete Medicaid eligibility categories. It would also yield important equity gains. Currently, some population groups are covered to relatively high income levels, while others are ineligible for Medicaid no matter how poor they are.

Conditioning eligibility on income alone could, however, terminate coverage for persons in categories that extend well above the new income threshold. If, for example, the Medicaid eligibility threshold were set at 150 percent of FPL with no coverage for people above that level, a number of groups would lose Medicaid coverage. Altogether, 4.4 million nonelderly adults and 6.4 million children from families with incomes above 150 percent FPL currently receive Medicaid or SCHIP (KCMU/UI, 2007). Even if those individuals were grandfathered

in and continued to receive Medicaid, similar people in the future would not receive coverage. Groups that currently receive Medicaid above the 150 percent of FPL threshold include the following:⁹

- Transitional Medical Assistance (TMA) provides six months of Medicaid, without any income limits, to families transitioning from cash assistance to employment. After six months, families are entitled to another six months of TMA if their income is at or below 185 percent of FPL (Schneider et al., 2002).
- Forty-six states and the District of Columbia cover children whose special needs would make adoption very difficult without Medicaid coverage. This category applies without regard to the income of the adopting parents (Schneider et al., 2002).
- Thirty-one states provide medically needy coverage to seniors and people with disabilities (NASMD, undated). Under this category, medical expenses are subtracted from income to determine eligibility, so income can reach any level, no matter how high, as long as medical expenses are sufficiently great. This category typically provides coverage to nursing home residents, people with a chronic illness that is very expensive to treat, and victims of a catastrophic accident or acute illness.
- Thirty-seven states cover pregnant women up to 185 percent of FPL or higher; 12 states go up to 200 percent of FPL and 5 go even higher, including several that go as far as 300 percent of FPL (Cohen Ross et al., 2007).

The National Academy for State Health Policy (NASHP) suggested an alternative approach to converting Medicaid into a noncategorical program. NASHP proposed guaranteeing Medicaid coverage up to 100 percent of FPL, regardless of category, granting states the discretion to go above that income level for categories defined by state law, with one exception—current

9 In addition to the groups listed here, Medicaid covers many children with incomes above 150 percent of FPL. Infants under age one are covered up to 200 percent of FPL in 17 state Medicaid programs. In seven other states, infants are covered at levels as high as 300 percent of FPL (Cohen Ross et al., 2007). For children through age five, seven states currently use existing Medicaid statutory authority to provide coverage for children in families with income up to 200 percent of FPL, and six states cover children above this level, in some cases up to 300 percent of FPL (Cohen Ross et al., 2007). Sections 6061 and 6062 of the Deficit Reduction Act of 2005 give states the option to extend Medicaid to certain children with disabilities in families with incomes up to 300 percent of FPL. These are children who are sufficiently disabled to qualify for SSI but whose household incomes or assets exceed state-established limits and whose parents have enrolled their families in employer-sponsored insurance. Other eligibility groups that extend above 150 percent of FPL include the following: eight states cover working parents of dependent children with incomes above 190 percent of FPL (Cohen Ross et al., 2007); several eligibility categories extend coverage of home- and community-based services, regardless of parental income, to severely disabled children who would qualify for Medicaid if they were institutionalized (Schneider et al., 2002); and multiple eligibility categories permit states to cover working people with disabilities who have incomes up to 250 percent of FPL or even higher (Schneider et al., 2002). Under Section 1915(c) of the Social Security Act, states can obtain waivers permitting them to provide home- and community-based services to severely disabled adults, regardless of spousal income, if such adults would qualify for Medicaid if they were institutionalized (Schneider et al., 2002), and 34 states extend Medicaid eligibility to elderly and disabled people in nursing homes (and, in some cases, to people receiving home-based care as an alternative to institutionalization) with incomes at or below 300 percent of the SSI benefit (NASMD, undated)—in 2006, this amounted to 222 and 247 percent of FPL for single individuals and couples, respectively.

mandatory eligibility for young children and pregnant women would be retained up to 133 percent of FPL (Smith et al., 2005). Under this policy, there would be no upper income limit, but states could make their own rules to determine which residents with incomes above the FPL would receive Medicaid. Put differently, categorical eligibility would end for poor adults, but categorical eligibility could continue above the FPL, albeit with substantially increased state discretion to structure the categories as they see fit. Such flexibility to cover the nonpoor who are outside current eligibility categories could raise federal spending for people with incomes above the FPL. Policymakers who seek to avoid that result could consider such steps as lowering federal matching percentages for higher-income enrollees who are ineligible under current law.

CREATE A NEW MEDICAID ELIGIBILITY CATEGORY FOR ALL ADULTS WITH INCOMES BELOW SPECIFIED LEVELS

Another approach to providing Medicaid coverage for noncategorical adults is similar to the NASHP proposal—it would establish a new statutory eligibility category for adults based purely on income. Adults with incomes below specified levels would automatically qualify for Medicaid whether or not they fit into current federal eligibility categories. Like the NASHP proposal, this approach would allow other Medicaid eligibility categories to cover persons with a family income higher than the new income limit. Unlike the NASHP approach, it would retain current eligibility categories above the new level, rather than granting states the flexibility to rearrange those categories.

This alternative has two disadvantages compared with more sweeping approaches. Medicaid would remain complex, with more than 50 eligibility categories, yielding less administrative savings than eliminating categorical eligibility altogether. As noted above, it is costly for state staff to match each application against multiple eligibility categories to see if it fits one of the categories. While it would not completely eliminate the need for such administrative work, adding a significant income-based eligibility group would greatly reduce this workload, as most eligible applicants would be covered under the new income-based category. Only in the minority of cases, where income-based eligibility did not cover an applicant, would state officials need to examine the potential applicability of other categories.

Equity problems would persist in this approach, albeit in a less acute form than under current law. All adults would receive coverage up to the specified income level, so it would no longer be true that some are covered to relatively high income levels while others are ineligible no matter how poor they are. On the other hand, some eligibility groups would continue to receive coverage at higher income levels than others.

TWO FINAL COMMENTS

In the discussion of these three approaches, two final comments are in order. First, extending Medicaid to millions of poor adults who lack coverage today will be costly, no matter how it is structured. Second, there are good reasons to maintain some of the coverage categories that extend Medicaid to relatively high income levels.

For example:

- When pregnant women receive prenatal care, their babies are less likely to need expensive neonatal care or to develop serious, long-term health problems. Thus, covering these women yields financial gains that may not apply to other populations.
- Transitional Medicaid coverage for up to 12 months when families move from cash assistance to employment encourages movement toward self-sufficiency, a policy consideration that may be less relevant to many other eligibility groups.
- Medically needy coverage serves people whose disposable income is reduced to very low levels by their medical bills. In important ways, they are just as indigent as people with higher incomes but fewer medical costs.

Policymakers should carefully consider the policies that underlie different income standards for different eligibility categories. In some cases, these factors may justify the seeming inequities that would remain if Medicaid covered only select categories of individuals with incomes above a specified level, such as 100 percent or 150 percent of FPL. It may be important to retain an option for states to cover people above the income threshold, using either current eligibility categories or a more open-ended approach.

POLICY DESIGN CHOICES

Regardless of the approach policymakers pursue, they will need to resolve important policy design questions related to federalism and financial eligibility.¹⁰

FEDERALISM ISSUES

One set of questions involves whether new coverage would be optional or mandatory for states and what level of financial support the federal government would provide. At one extreme, income-based coverage for adults could be an option for states, with federal matching funds offered at current levels. Under that approach, however, many states might not take advantage of this option because of the cost.

To encourage state implementation while keeping the coverage expansion optional, the federal government could increase its financial support for states that elect to provide income-based coverage for adults. For example, these adults could receive a particularly high matching percentage, just as SCHIP provides an enhanced federal match that lowers the state share to 30 percent below standard Medicaid levels. Alternatively, each state that implements the new coverage category could receive an increased program-wide federal matching percentage.¹¹ Under the latter approach, states would have no incentive to “game the system” by encouraging enrollment of one group at the expense of another.

Finally, federal policymakers could simply require all states to cover adults up to a certain percentage of FPL, just as Medicaid currently mandates for children. Policymakers could accompany this requirement with sufficiently enhanced federal funding levels to compensate states for the resulting increased costs. Such increased federal funding could be delivered in many different ways, ranging from an increased Medicaid matching percentage to a federal assumption of some current Medicaid costs for elderly and disabled persons who dually qualify for Medicaid and Medicare.¹²

10 Because this analysis assumes that Medicaid eligibility for noncategorical adults would be limited to those with very low incomes —perhaps up to only 100 or 150 percent of FPL—it does not consider issues involving the interaction with employer-sponsored insurance, which would be critically important to address for any subsidy system serving persons above these very low income levels. For the same reason, this analysis also does not address whether Medicaid’s normal rules for covered benefits and cost sharing would apply at relatively high income levels.

11 This approach to providing increased federal financial support was included among many Medicaid reform options discussed by Holahan and Weil (2007).

12 In addition, states with unspent allocations for DSH could be allowed through state plan amendments rather than waivers, to use those dollars to offset the costs of coverage expansion.

FINANCIAL ELIGIBILITY

Policymakers seeking to cover noncategorical adults would need to consider how high to extend income eligibility and whether to limit coverage to adults with assets below specified levels. Reaching 100 percent of FPL would significantly decrease the number of uninsured in this country, since the largest group of uninsured noncategorical adults—fully a third, or 8.9 million people—have incomes below that level (figure 2, above). Raising Medicaid eligibility to higher levels would have a greater impact on coverage, along with a corresponding increase in cost.

In deciding how to balance this cost-coverage trade-off, several factors may be helpful for policymakers to consider. First, at low income levels, many people lack access to employer-sponsored insurance (ESI), creating a need for publicly funded subsidies. In 2005, 55 percent of poor workers and 35 percent of employees with incomes between 100 and 199 percent of FPL had no access to ESI through any family member (Clemans-Cope and Garret, 2006). Without access to ESI, few of these workers can afford health coverage. Among low-income people who seek coverage in the nongroup market, 72 percent report that it is very difficult or impossible to obtain affordable coverage; only 7 percent complete the process and buy such a health plan (Collins et al., 2006).

A second factor involves identifying the income level below which Medicaid has a comparative advantage over other methods of providing health coverage. For populations with very little disposable income, Medicaid's traditional absence of significant cost sharing is important in making enrollment affordable and preventing out-of-pocket costs from obstructing access to care. Medicaid's additional benefits are also important to a population that lacks the financial ability to purchase even comparatively inexpensive health care services, including routine vision and dental care. Although Section 6044 of the Deficit Reduction Act of 2005 (DRA) granted states permission to provide less generous benefits to certain populations, few states have taken advantage of this flexibility.

It is not easy to determine the income level below which households lack the disposable income to pay for coverage. Analysts have tried to determine subsistence income levels by setting the Family Economic Self-Sufficiency Standard for 35 states and two cities, estimating, in each geographic area, the amount of money required to meet subsistence needs such as food, clothing, shelter, and transportation to work.¹³ In each state, income well above the FPL is needed to provide for such necessities, leaving no room in household budgets for health insurance premiums. In this context, it is noteworthy that, under DRA sections 6041 and 6042, premiums may not be charged to beneficiaries with incomes at or below 150 percent of FPL.

In addition to determining eligibility standards for *income*, policymakers would need to decide whether and how to limit coverage to adults with *assets* below a specified value. No previous research of which the author is aware analyzes the asset ownership patterns of noncategorical

13 See Family Economic Self-Sufficiency State Projects, www.sixstrategies.org/states/states.cfm, accessed on April 1, 2008.

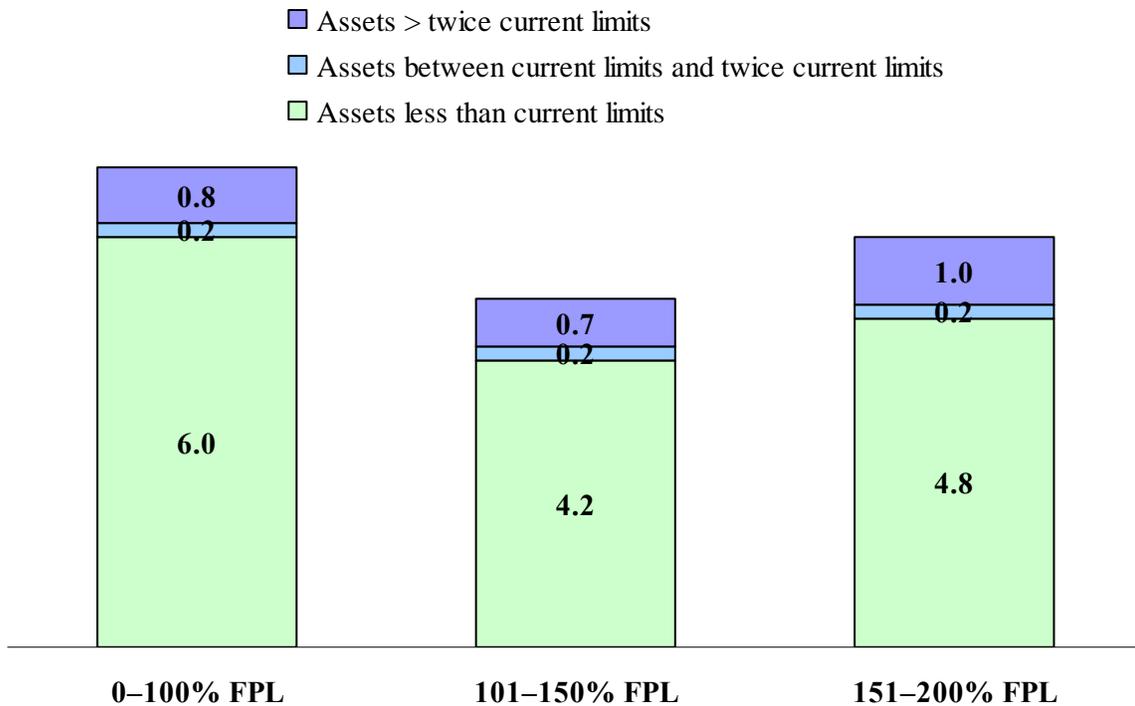
adults. To fill that gap, Kenneth Finegold, Paul Johnson, and Jessica Kronstadt of the Urban Institute estimated the impact of various asset and income thresholds on the number of noncategorical adults who would be newly eligible for Medicaid.

To develop their estimates, Finegold and colleagues used the Urban Institute's TRIM3 microsimulation model, which includes information on every Medicaid and SCHIP eligibility category in every state as of 2002. It also includes information about the characteristics of each state's residents in that year, as shown by Census Bureau data.¹⁴ An important limitation of the TRIM3 model is that it imputes values for personal assets, because these values cannot be derived from the census data included in the model. TRIM3 imputes these values from reported interest, dividend, and rental income, which may somewhat understate the assets held by particular households.

Notwithstanding that limitation, Finegold and colleagues found that the vast majority of noncategorical adults with incomes at or below 200 percent of FPL had assets below the lowest asset limits for Medicaid and SCHIP in their respective states (figure 17).

14 The estimates by Finegold and colleagues are based on simulations of Medicaid and SCHIP eligibility with the TRIM3 microsimulation model, maintained and developed by the Urban Institute under primary funding from the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. TRIM3 uses data from the Annual Social and Economic Supplement to the Current Population Survey (March CPS) to simulate health coverage under Medicaid, SCHIP, and ESI, as well as key transfer programs and federal and state taxes. Federal and state policies affecting eligibility are modeled in great detail. To correct for the underreporting of participation in means-tested programs, TRIM3 adjusts reported participation in Medicaid and SCHIP to meet targets based on administrative data. For the estimates in this report, Finegold and colleagues calculated the number of noncategorical adults, as defined in the text, who would have qualified for Medicaid with incomes and assets up to specified levels. They determined the number of persons ages 19–64 who were not parents, caretakers for dependent children, pregnant, or disabled. They excluded two groups from the set: (1) all people whose immigration status disqualified them from full Medicaid eligibility and (2) all people who qualified for Medicaid or SCHIP under existing laws. The remaining adults were deemed noncategorical. They then determined the number of noncategorical adults who would be newly eligible for Medicaid in each state if income eligibility for such adults extended to various percentages of FPL (100, 150, and 200 percent). Within each income category, they determined the number whose assets fell below the lowest Medicaid/SCHIP asset limit that applied to any eligibility group. If no asset limits applied in any Medicaid or SCHIP category, they used the state's asset limit for Temporary Assistance for Needy Families (TANF). They also determined the number whose assets were between 101 and 200 percent of those asset thresholds and the number whose assets were worth more than twice the base limit.

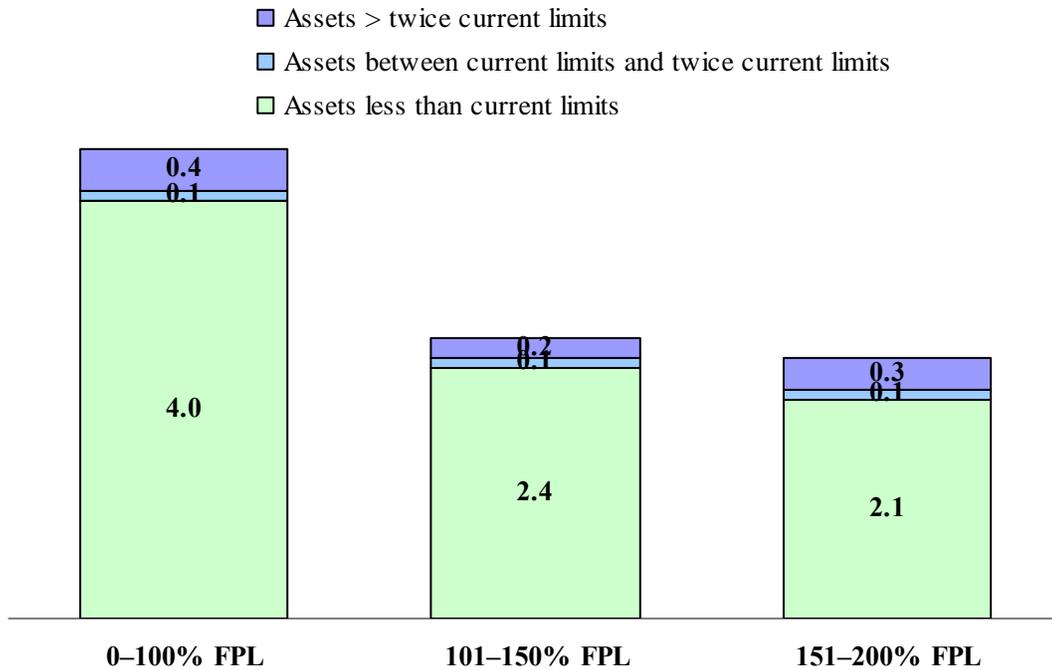
Figure 17: Noncategorical Adults Ineligible for Medicaid, by Income and Assets (millions): 2002



Source: TRIM3 microsimulation model. Notes: (1) Results show—among the noninstitutionalized population ages 19–64 who are not pregnant, disabled, or caring for dependent children and whose immigration status does not disqualify them from full Medicaid eligibility—the average monthly number of persons who would gain Medicaid eligibility if income and asset limits were set at specified levels. This includes some persons who are not categorically ineligible for coverage in their state because their state covers certain 19- and 20-year-olds as children or covers childless adults under 1115 or SCHIP waivers, but whose income and assets are too high for eligibility under current law. (2) Current asset limits in each state are the lowest limits that apply to any category, including TANF recipients in a state without otherwise applicable asset limits.

Among categorically ineligible adults who were uninsured, even fewer had assets above current Medicaid thresholds (figure 18).

Figure 18: Uninsured Noncategorical Adults Ineligible for Medicaid, by Income and Assets (millions): 2002



Source: TRIM3 microsimulation model. See figure 17 notes.

Asset requirements would exclude very few otherwise eligible persons among both the lowest-income noncategorical adults and those in this group who lack insurance. At the same time, when Medicaid applicants must document the extent and value of their assets, large burdens are imposed on families and eligibility staff alike, raising administrative costs and reducing enrollment (Summer and Thompson, 2004; Lewin Group, 2003). In fact, research on children's coverage programs suggests that asset tests may be the single most significant procedural barrier to completion of the Medicaid application process (Kronebusch and Elbel, 2004a and 2004b; Bansak and Raphael, 2005). The modest gain from asset tests, in terms of targeting public dollars toward the neediest noncategorical adults, may thus be outweighed by their tendency to prevent eligible individuals from enrolling. The following factors also counterbalance the minimal effect of asset tests in screening out those who can afford coverage:

- The administrative costs to states of evaluating whether particular applicants have too many assets to qualify for coverage;
- The role of asset tests in complicating eligibility determinations, hence increasing the likelihood of errors and the consequent risk of federal financial sanctions; and
- The impact of asset tests in deterring the accumulation of retirement savings.

CONCLUSION

Low-income adults who fall outside Medicaid's eligibility categories comprise the largest group of uninsured persons in America. For many of these adults, the lack of health coverage means inability to obtain essential health care, sometimes with fatal results. Opinion research suggests strong public support for extending Medicaid to all low-income adults, regardless of category. Viable policy options are available to help this group of uninsured persons. Changing the basic limitation on Medicaid eligibility deserves serious consideration by policymakers who are deciding how to structure major national health care reforms.

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APPENDIX A

SUMMARY OF MEETING CONVENED BY AARP PUBLIC POLICY INSTITUTE TO DISCUSS OPTIONS FOR COVERING NONCATEGORICAL ADULTS

Many Americans mistakenly believe that Medicaid provides health insurance for the poor. In reality, state Medicaid programs typically cover adults only if they are pregnant, caring for dependent children, severely disabled, or elderly. States do have the right to apply for federal waivers to cover other groups, but these waivers are rarely used because they have to be budget neutral.

The bulk of the uninsured are low-income adults who do not fit into the federally defined Medicaid categories. They range from young adults starting out in the working world to empty-nesters in their 50s and 60s. Many of these uninsured people go without essential care, which in some cases contributes to preventable deaths.

On December 12, 2007, the AARP Public Policy Institute convened a meeting of Medicaid experts in Washington, DC, to explore options for extending health coverage to low-income adults. The meeting sparked a candid dialogue among state and national policymakers and organizations representing providers and consumers.

VEHICLES FOR EXPANDING COVERAGE

The participants began by looking at whether Medicaid is the most appropriate vehicle for providing health coverage to the uninsured. They generally agreed that Medicaid was a good choice for covering adults up to a certain income level. Opinions varied as to whether Medicaid should extend to 100 percent of federal poverty level (FPL) or 150 percent of FPL. Above that threshold, participants discussed other approaches, such as tax credits, premium subsidies, buy-ins, and insurance market reform.

Within these parameters, the discussion turned to strategies for achieving a Medicaid expansion. Some participants favored changing Medicaid from a category-based program to an income-based program. They argued that this shift would simplify policy and eliminate debate over which groups are “deserving.” The key challenge would be how to transition current higher income beneficiaries who would be above the new income threshold and how to offer states the flexibility to determine who receives coverage above that threshold.

A second approach would be to keep the current categories but add a new category for the poor. Some argued for a national floor, while others thought that would be too costly for states. An alternative suggestion was to require states to cover low-income adults up to the same percentage of FPL as their lowest existing category or to phase in coverage gradually, perhaps based on income.

The third approach would be to make the waiver process more flexible, allowing states to obtain additional federal funds. Many participants said that the federal budget neutrality requirement should be liberalized to take into account potential Medicare savings that will result from keeping adults healthier before they become eligible for Medicare. Proponents of waivers noted that they allow for local customization and help provide valuable services such as language

support. Critics argued that the waiver process is costly and cumbersome, and subject to the whims of changing administrations.

Looking beyond Medicaid, participants touched on other strategies for covering uninsured adults. Some of the ideas posed were premium assistance for the working uninsured and tax credits for small businesses that offer insurance to employees. Other suggestions included allowing businesses and individuals to purchase coverage through the state, or using state funds to let individuals choose among select private plans. Participants also raised the idea of a Medicare buy-in for people ages 55–64 years.

A number of these alternatives are already being tested in various states; however, many appear to be best suited for people above 100 percent of FPL.

ELIGIBILITY

Discussion continued with the goal of outlining what an income-based Medicaid expansion might look like. Many participants called for mandatory, phased-in eligibility up to 100 percent of FPL. However, it was noted that one limitation of FPL is that it does not take into account geographic differences in the cost of living.

Critics worried that mandating coverage would burden states, lower payments to providers, and exacerbate problems with access. To overcome these concerns, there was general agreement that the expansion must be in conjunction with increased federal support, better payments for providers, and improved coordination between Medicare and Medicaid.

With respect to asset tests, most participants said they should be softened or eliminated entirely. One idea was to allow each state to decide whether or not to impose a test.

Overall, asset tests were viewed as a major barrier to enrollment. Many participants believed that they produced little savings when weighed against their administrative costs. The only area where asset tests were seen as valuable was for those using Medicaid primarily to cover long-term care.

The topic of asset tests sparked a broader discussion on the merits of streamlining enrollment. One example cited was New York's post-September 11 temporary disaster-relief Medicaid program, which involved a one-page application and almost instant access. It was believed that the simplified application process contributed to the success of the program, which enrolled more than 300,000 people in only four months.

Regarding how to address existing Medicaid coverage that extends to higher incomes, a popular premise was that no one should lose coverage; however, some participants said that some categorically eligible individuals might be transitioned to other programs through tax credits, employer subsidies, or a Medicare buy-in.

FINANCING

Turning to financing, participants explored various avenues for paying for a Medicaid expansion. One study estimated that it would cost \$25 billion to cover up to 100 percent of FPL through voluntary enrollment, and \$40 billion to cover up to 150 percent.

Participants began by discussing the idea of an enhanced Federal Medical Assistance Percentage (FMAP). This “sale” on federal money was viewed as causing less pain in the short term, since the federal government has more budget flexibility than the states. To avoid the formula fights that have traditionally plagued the FMAP, some suggested an across-the-board percentage increase. They thought an enhanced FMAP would be particularly attractive to states at this time, since there are few other sources of new revenue.

Another recurring theme was to find a more efficient way to address dual eligibles. Many believed that it would be better stewardship of the federal dollar to have one payer responsible for this population. They acknowledged, though, that political obstacles would need to be surmounted.

A third idea was to redirect money currently being used for disproportionate share hospital (DSH) payments. However, some participants cautioned that DSH payments play an important role in providing care for undocumented persons. One suggestion for overcoming this concern was to create a new program tightly targeted toward public health facilities.

There was also a call for states to show better value in both their basic and expanded Medicaid programs. Other suggestions included looking at cost-containment efforts in the private sector and trying to apply a medical home model to Medicaid. Finally, there was a suggestion to fund Medicaid's expansion through a “snack tax,” similar to the tobacco tax that helped pay for the State Children's Health Insurance Program (SCHIP).

However, should waivers remain the primary avenue for expansion, participants favored softening the budget neutrality requirement. Many would like to see a formula that takes into account future savings to Medicare. One suggestion was a state demonstration project focused on chronic care management and cost containment.

BENEFITS AND COST SHARING

The discussion then turned to what the Medicaid benefit should look like, under the assumption that it would be universal for those up to a specified income threshold, such as 100 percent of FPL. Many participants said they would like to know more about the population such a benefit would be likely to attract.

Overall, participants seemed to favor the traditional Medicaid package. However, some said that states should have the authority to narrow the provider network to achieve greater efficiencies.

There was also discussion about whether there should be a requirement aimed at managing care. One suggestion was to include language mandating the use of electronic health records.

Regarding cost sharing, participants generally agreed that the amount of money those under 100 percent of FPL could contribute would have little impact on the system. They cautioned that cost sharing would be a major barrier to access and a burden for beneficiaries who require frequent care.

On the flip side, participants acknowledged that it is politically difficult to “sell” an expansion without cost sharing. One idea was to have nominal cost sharing that could be waived.

Participants then considered whether premium assistance programs are a good way to transition low-income people into employer-sponsored coverage. Some suggested that the working poor should have the option, but with no wraparound except for cost sharing. Others believed that, instead of a wraparound, there should be only an income-related stop loss.

Critics doubted that the savings to Medicaid would outweigh the administrative costs for those under 100 percent of FPL. They also noted that there is high turnover among the working poor and suggested that Medicaid would provide more coverage for the dollar spent. They stressed that any premium assistance model should include a strong cost effectiveness test.

Another idea raised was allowing employers to buy in to state Medicaid programs. New York and Oklahoma are currently experimenting with this model, and so far the concept has been well received.

THE POLITICAL LANDSCAPE

The final topic of discussion focused on prospects for progress in light of the current political landscape. Participants were generally pessimistic about the outlook for 2008, saying that little will be accomplished at the federal level until after the presidential election. Some people said it would be difficult to find congressional support for a Medicaid expansion that would increase the federal deficit. With these factors in mind, some participants believed that the best chance for progress would be at the state level. Others were optimistic that a new political climate following the 2008 elections could provide a significant opportunity for a Medicaid expansion to cover all of the poor.

Some participants suggested that AARP narrow the goal for coverage. One idea was to focus on those ages 55–64—perhaps through a Medicaid buy-in. Another thought was to target the highest cost, chronic illness groups that will eventually end up on Medicare.

Others believed that AARP should aim high because there is substantial public support for covering the low-income uninsured. One participant cited a recent study by the Federation of American Hospitals that found the uninsured poor to be one of the most sympathetic groups and found that more than 70 percent of respondents favored expanding Medicaid to cover all poor adults. Some participants noted that, following the SCHIP debate, a number of Republicans would be more likely to support covering poor adults than higher-income children.

CONCLUSION AND NEXT STEPS

Millions of low-income Americans who do not fit into one of Medicaid's eligibility categories are living without health insurance and essential care. There was general support among the meeting participants for an income-based Medicaid expansion that would cover people up to 100 percent or 150 percent of FPL. Above that threshold, participants discussed other approaches, such as tax credits, premium assistance, buy-ins, and insurance market reform.

A number of participants said that mandatory, phased-in eligibility (by age or chronic health condition) would be the most effective way to achieve the Medicaid expansion. Under this model, asset tests would be softened or eliminated and cost-sharing would be nonexistent or nominal.

Debate continued over the best way to finance a Medicaid expansion. Some possible avenues include an enhanced FMAP, better use of the money spent on dual eligibles, and redirection of DSH dollars. It was suggested that dollars might be found by increasing the focus on preventive care and by borrowing cost-containment measures from the private sector.

While many participants favored extending Medicaid to all adults with incomes below a threshold level, they acknowledged the challenges of the current political landscape. If waivers remain the primary avenue for expanding coverage, they believe that the budget neutrality requirement should be liberalized to take into account future savings to Medicare.

Regardless of the final coverage goal, most participants believed that a key role for AARP would be public education and mobilization. Participants proposed the following messages to help frame the issue of covering low-income adults:

- Many Americans mistakenly believe that Medicaid provides health insurance for the poor. In reality, state Medicaid programs typically cover adults only if they are pregnant, caring for dependent children, severely disabled, or elderly.
- It will cost money to make sure that everyone who is poor has health insurance, but it's a goal worth pursuing.
- It makes no sense for low-income seniors to get some care (and prescription drugs) from Medicare and some from Medicaid.
- Medicaid should be the place for people who cannot get private insurance, but we cannot let insurers and employers off the hook.

**—Michelle Hayunga, Hayunga Communications
and Lynda Flowers, AARP Public Policy Institute**

APPENDIX B

**Uninsured People with Incomes at or below the Federal Poverty Line,
by State, Relationship to Children, and Age: 2004–2006**

	Poor Uninsured (thousands)	Percentage Childless Adults	Percentage Age 50 to 64	Percentage Age 65 and Older
United States	16,596	55%	12%	2%
Alabama	285	56%	15%	1%
Alaska	31	59%	12%	2%
Arizona	415	44%	10%	2%
Arkansas	185	56%	12%	0%
California	2,430	53%	11%	3%
Colorado	263	46%	10%	2%
Connecticut	108	60%	12%	1%
Delaware	32	55%	10%	2%
District of Columbia	27	70%	15%	3%
Florida	1,158	56%	12%	2%
Georgia	559	54%	12%	1%
Hawaii	48	72%	13%	3%
Idaho	54	54%	14%	1%
Illinois	729	57%	13%	2%
Indiana	282	60%	9%	0%
Iowa	97	64%	12%	1%
Kansas	116	56%	11%	3%
Kentucky	243	56%	11%	0%
Louisiana	364	59%	14%	1%
Maine	35	66%	18%	1%
Maryland	284	59%	13%	3%
Massachusetts	204	74%	8%	2%
Michigan	435	65%	11%	1%
Minnesota	140	60%	9%	2%
Mississippi	249	49%	10%	1%
Missouri	251	56%	12%	1%
Montana	55	52%	16%	1%
Nebraska	69	55%	9%	2%
Nevada	161	53%	10%	2%
New Hampshire	35	65%	16%	2%
New Jersey	410	58%	13%	4%
New Mexico	150	51%	11%	1%
New York	947	66%	14%	2%
North Carolina	498	54%	16%	1%
North Dakota	21	59%	16%	0%
Ohio	473	65%	13%	1%
Oklahoma	243	50%	10%	1%
Oregon	210	60%	14%	1%
Pennsylvania	485	58%	10%	2%
Rhode Island	36	67%	12%	2%
South Carolina	228	63%	10%	1%
South Dakota	31	56%	12%	1%
Tennessee	295	59%	11%	1%
Texas	2,206	43%	12%	2%
Utah	130	44%	9%	0%
Vermont	14	73%	16%	0%
Virginia	317	57%	12%	3%
Washington	243	61%	11%	2%
West Virginia	105	64%	13%	1%
Wisconsin	193	65%	15%	1%
Wyoming	20	55%	10%	1%

Source: Urban Institute, 2008. Based on tabulations from the 2005, 2006, and 2007 *Annual Social and Economic Supplement to the Current Population Survey*.

Note: Due to small sample sizes of uninsured poor for some state-level estimates, the above tabulations reflect merged data from the 2005, 2006, and 2007 CPS and are current to 2004, 2005, and 2006.



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